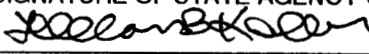




<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <div style="text-align: center;">0 4 — 0 0 7</div>	2. STATE: <div style="text-align: center;">HAWAII</div>
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) MEDICAL ASSISTANCE	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE  <div style="text-align: center;">01/01/05</div>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  SECTION 1902 (V) OF THE ACT		7. FEDERAL BUDGET IMPACT: a. FFY <u>NONE</u> \$ _____ b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  SUPPLEMENT 6 TO ATTACHMENT 2.6-A		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  SUPPLEMENT 6 TO ATTACHMENT 2.6-A	

10. SUBJECT OF AMENDMENT:

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

11. GOVERNOR'S REVIEW (Check One):  <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: AS APPROVED BY GOVERNOR
12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  DEPARTMENT OF HUMAN SERVICES MED-QUEST DIVISION POLICY AND PROGRAM DEVELOPMENT OFFICE P. O. BOX 700190 KAPOLEI, HI 96709-0190	
13. TYPED NAME: LILLIAN B. KOLLER, ESQ.		
14. TITLE: DIRECTOR		
15. DATE SUBMITTED: <b>DEC 02 2004</b>		

<b>FOR REGIONAL OFFICE USE ONLY</b>	
17. DATE RECEIVED: <div style="text-align: center;">Dec. 7, 2004</div>	18. DATE APPROVED: 
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center;">January 1, 2005</div>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <div style="text-align: center;">Linda Minamoto</div>	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

SUPPLEMENT 6 TO  
ATTACHMENT 2.6 - A

State HAWAII

Standards for Optional State Supplementary Payments

Payment Category	Administered by		Income Level				Income Disregards
(Reasonable Classification)	Federal	State	<u>Gross</u>		<u>Net</u>		Employed
			1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X						
- LEVEL I	\$579	\$521.90	\$1,737	N/A	\$1,100.90	N/A	
- LEVEL II	\$579	\$629.90	\$1,737	N/A	\$1,208.90	N/A	

NOTE: \*Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.

\*\*Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit

TN No. 04-007

Supersedes

TN No. 03-007

Approval Date:

FEB 01 2005

Effective Date:

01/01/05